STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012233	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHYSIOCARE HOME HEALTHCARE LLC	625 SOUTH EARL AVENUE, STE D LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments State Licensure This was a state home health licensure survey done in conjunction with two complaints: IN00192340 and IN00167061, both unsubstantiated due to insufficient evidence. Survey dates: July 1 to July 7, 2016 Facility Number: 012233 Medicaid Provider: 200973060 Census: 84 Home visits: 5 Clinical records reviewed: 12 Premier Home Health Indiana was found to be in compliance with 410 IAC Article 17.	N 000		